of the superficial layers of the crystalline lens. Syphilitic retinitis and choroiditis, as well as iritis, are developed most frequently in an advanced stage of the constitutional affection, and belong to the secondary as well as to the tertiary phenomena.

2. In most cases, the functional symptoms of syphilitic retino-choroiditis are the following. *a.* There are asthenopia, trembling and uncertain vision, photophobia, visions of globes of fire or black spots, chromatopsy or pseudo-chromatopsy, and muscæ volitantes. *b.* There is a gradually increasing weakness of the power of vision. *c.* The field of vision becomes progressively limited from the circumference until it is limited to a narrow space. Frequently also obscurity commences in the centre of the field of vision. In either case, sight may remain limited, or may extend little by little. *d.* The hemeralopia which is often observed in cases of degeneration or pigmentary infiltration of the retina in syphilitic subjects, is a phenomenon which appears very late, and appears to be the effect of loss of sensibility in the retina and progressive atrophy of the papilla. *e.* If constitutional syphilis have produced periostitis of the orbit or a swelling implicating the filaments of the fifth pair of nerves, the patient experiences, independently of impaired vision, violent supraorbital neuralgia, with nocturnal exacerbations; exophthalmia may even be produced: there is then a severe almost constant pain in the temporal and frontal regions. The motor nerves alone may be attacked.

3. These affections have generally a very slow, often irregular course.

4. In the early period of syphilitic retinitis, antiphlogistics and resolvents are employed with advantage, especially if symptoms of inflammation be present. When these are absent, the simple fact of impairment of vision in a syphilitic subject indicates the use of a specific treatment—mechanical friction, iodide of potassium, etc. Tonics should be added, if there are threatenings of atrophy of the retina. Under such treatment, patients have almost entirely recovered sight.

5. Cure is no longer possible when atrophy of the retina actually exists. Other nerves than the optic may, when affected, return more readily to their normal state, by reason of their structure being less complicated. If the retina be slightly obscured, but the columnar layer remain intact, there will be only impairment of vision for distant objects.—*British Med. Journ.*, Feb. 10, 1866, from *Gaz. Méd. de Paris*, November 11, 1865.

MIDWIFERY.

42. *Causes of the Position of the Fœtus.*—Prof. von Scanzoni, of Würzburg, sums up a paper on the causes of the frequency of the head-presentation in the human fœtus, with the following conclusions. 1. The frequency of the cranial position of the embryo during pregnancy is not explained by Simpson's theory of reflex movements of the fœtus; nor, as alleged by Dubois, by its instinctive movements; nor by the hypothesis of Carus, according to which the fœtus lives a mere vegetable life within the uterus. 2. The position of the fœtus is dependent on the operation of various circumstances: viz., *a*, the force of gravitation; *b*, the form of the uterine cavity; *c*, the form of the fœtus; *d*, the quantity of amniotic fluid; *e*, the contractions of the uterus during pregnancy and the first stage of labour; and *f*, the active movements of the fœtus. 3. Up to the time when the placenta is developed, the embryo may assume any position, vertical or horizontal, in the cavity. 4. Immediately after the formation of the placenta, the fœtus is suspended at its lower end by a very short umbilical cord to the upper part of the uterus, and the large heavy head hangs downwards. 5. This position may, in favourable circumstances, be maintained during the whole of pregnancy; but much more frequently it undergoes changes into other positions, from which, as a rule, a return is finally made to the head-presentation. 6. The first of the causes influencing the position of the fœtus is the rapid

growth of the umbilical cord, which becomes even longer than the uterus, and thus is no longer capable of retaining the lower part of the body of the fœtus in the upper part of the uterus. 7. The fœtus may nevertheless constantly retain a vertical position with the head directed downwards, since the centre of gravity falls within the large head, and the relatively large quantity of amniotic fluid keeps the fœtus floating until the middle of pregnancy, so that the heaviest part gravitates towards the lowest part of the circumference of the uterus. 8. About the middle of pregnancy, in consequence of the rapid development of the body of the fœtus, the centre of gravity falls from the head to the upper part of the thorax, and changes the gravitative relations of the fœtus. 9. If at the same time, as usually is the case, the uterus grows more in its longitudinal than in its transverse diameter, its walls retain the fœtus in the vertical position; since it has become too long for its long diameter to find room in the transverse diameter of the uterus. 10. But if the uterine cavity become more roomy, the head may be inclined to either side, so that an oblique or even a transverse position may be assumed. 11. As the fœtus increases further in growth, the quantity of amniotic fluid diminishes in proportion to the size of the fœtus, and, if the lateral walls of the uterus be not unusually yielding, the fœtus is compelled to resume a vertical position. 12. If the head have hitherto remained the deepest part, it will be the point which in the perpendicular portion of the uterus comes most readily over the os uteri. 13. When the fœtus lies transversely, the manner in which the child presents depends partly on the resistance of the uterine walls, partly on the active movements of the fœtus induced by this resistance, but especially on the occurrence of contractions in the uterus. 14. In the transverse position, the head generally lies lower than the breech: this, and the circumstance that the centre of gravity of the fœtus lies nearer to the head than to the pelvic extremity, render it plain how, when the pressure exercised by the sides of the uterus on the head and breech of the fœtus becomes troublesome, the head is directed downwards more readily than upwards when the fœtus assumes the perpendicular position. 15. The action of the uterine contractions on the transversely lying fœtus varies, according as the contractions originate in single parts of the uterus or over the whole organ. 16. Partial contractions, as a rule, set in most strongly at the points of the uterine wall which are in immediate contact with the head and breech of the fœtus; they act directly on the fœtus, and, if it be only moderately movable, very readily bring it into the vertical position; and the head, generally lying lower, enters the strait of the pelvis more readily than the breech, the expulsion of which requires a more complicated mechanism than that of the head. 17. The contractions extending over the whole uterus act most directly on the pelvic end of the fœtus, which is usually directed upwards, even in the oblique and transverse positions. If the lower section of the uterus contract powerfully, this circumstance may, in spite of the downward pressure exerted on the breech by the fundus uteri, succeed in bringing the head nearer to the middle line of the uterus and thus establishing a cranial presentation; and this action is essentially supported and favoured by the greater firmness and power of resistance on the part of the fœtal body. 18. If the contraction of the lower section of the uterus be less energetic, and the fœtus be at the same time young, soft, and compressible, the breech, under the simultaneous angular bending of the fœtus, is pressed still more deeply into the abdominal region, the head is pressed still further from the axis of the uterus, and the transverse presentation is thus finally converted into one of the breech or foot. 19. Hence the breech and foot presentations met with in such disproportionate frequency in abortion and premature labour are not primary positions, but are, as a rule, secondary, brought about by the contractions of the fundus uteri. 20. From the observations already made, it appears that the most various influences occurring during pregnancy may give rise to manifold changes of the position of the fœtus, but that nature generally succeeds in bringing the head over the os uteri, where it is usually found lying during the last six or eight weeks of pregnancy. 21. Nevertheless, changes of position are not especially rare even at this late period of pregnancy; and their occurrence is favoured if the quantity of amniotic fluid be great, if the embryonic cavity be roomy, if the uterine walls be yielding, and the active movements of the fœtus be energetic. The partial contractions of the uterus, which set in more frequently and with greater intensity in the last weeks of pregnancy, also exercise a powerful influence on the position of the fœtus. 22. In entirely normal relations, the deviation of the head after having once entered the pelvis, during the last weeks of pregnancy, is hindered when the quantity of amniotic fluid be remarkably diminished in proportion to the size of the fœtus, so that the size of the amniotic cavity and the mobility of the fœtus is diminished; and also when there is an arrest of the development of the uterine walls, so that the organ is extended by the growing fœtus. But this stretching of the walls of the uterus diminished its yielding power, and, by causing it to envelop the body of the fœtus more closely, renders difficult the occurrence of any important change of position.—*Brit. Med. Journ.*, March 17, 1866, from *Wiener Med. Wochenschrift,* Jan. 20, 1866.

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43. *Tetanus of the Uterus.*—Dr. DAVID GORDON related to the Obstetrical Society of Edinburgh (28th Feb. 1866) the case of Mrs. B., æt. 38, the mother of several children. During her pregnancy she had much bearing-down pain; the abdomen was very pendulous and partially supported on the thighs. The veins of the labia and limbs were varicose. The labour was very tedious. She began to complain of pain about 11 o'clock on a Monday night, and she was not delivered till 3 P. M. on the following Thursday, when Professor Simpson applied the forceps, and without much difficulty extracted a living child. To obtain a thorough examination, the patient was deeply chloroformed, and the hand was passed into the vagina through the brim, and fairly beyond the head of the child. The obstructing cause was then discovered. Firmly inclosing the neck of the child there was felt a broad and strong band of uterine fibres in a state of tonic contraction, which effectually prevented the passage of the shoulders through it. Several moderate pulls with the forceps, during the intervals between the pains, sufficed to overcome this obstruction, and delivery was speedily accomplished with perfect safety to mother and child, both of whom have done well. After the birth of the child there was a sharp attack of flooding. In removing the placenta the cord broke, and it became necessary to introduce the hand. The whole of the membranes remained in the uterus, and their removal was very troublesome. The flooding continued for some time, notwithstanding the vigorous use of cold and pressure. It appears to me that this case illustrates very clearly the great utility of chloroform in midwifery practice. Without the aid of such an agent it would have been impossible to make the thorough examination in the course of which the contracted and obstructing band of uterine fibres was discovered encircling the neck of the child and preventing its descent. It also shows that in skilful hands forceps may be applied to the head above the brim and fairly within the cavity of the uterus, without injury to mother or child. And I am confident that the practice, in such circumstances, is much safer than that of turning. This case also reminds us that when labour is retarded by the special cause indicated, the extracting force must not be applied as usual during the pains, but in the intervals between the pains.—*Edinburgh Medical Journal,* April, 1866.

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44. *Hemorrhage from the Uterus.*—Dr. BARNES stated, at a meeting of the Obstetrical Society of London (Feb. 7, 1866) that he continued the practice of injecting a solution of perchloride of iron into the uterus to arrest hemorrhage after abortion and labour, and with excellent effect. He no longer dreaded flooding as of old. So far he could illustrate by experience the safety of intra-uterine injections. But he thought a more desirable method of applying fluid styptics or caustics to the inner surface of the uterus would be by swabbing—that is, by soaking a bit of sponge or cotton-wool in the liquid, and passing it into the cavity. He had contrived an apparatus for this purpose. An excellent plan of applying solid nitrate of silver was one he had learned from Sir Benjamin Brodie. That eminent surgeon dipped a silver probe in fused nitrate of silver, thus obtaining a thin stratum, which could be passed freely and safely into a sinus. This was the safest way of cauterizing the inner surface of the cervix or body of the uterus.—*Med. Times and Gazette,* March 24, 1866.